OPINION

Coronary patients need cardiologists

Hugh J N Bethell

The ASPIRE study[1] found that, for the patients included in the survey, "recording and management of risk factors—lifestyle, blood pressure, cholesterol, glucose—and the use of prophylactic drug treatment were less than optimal". The authors present these findings as representative of the management of coronary patients across the country but I doubt whether this is true.

Patients were drawn from 12 specialist centres and 12 district general hospitals. The ratio of specialist centres to district general hospitals in the United Kingdom is much less than 1:1; therefore, there is an immediate bias in favour of better than average management. The district general hospital representatives named at the end of the paper seem all to be members of the British Cardiac Society. I appreciate that the samples of patients from their hospitals were not all looked after by the cardiologists themselves but they did presumably have the opportunity to influence local policy for the after care of acute myocardial infarction. There are still many hospitals in the UK which have no cardiologist to set such standards.

For these reasons I believe that the results produced by the ASPIRE study paint a rather rosy picture. The reality may be considerably worse.

Cardiologists have been chided for not applying optimal management to post-infarction patients[2]—for "favouring the excitement of event management over the boredom inherent in long term interventions"—and one of the ASPIRE authors has echoed this rebuke.[3] These criticisms ignore the fact that most heart attack patients are not looked after by cardiologists. In most district general hospitals acute infarction patients are admitted under the care of the general physician on call whose interest may be endocrinology, chest medicine, nephrology, gastroenterology or, sometimes, cardiology. A large proportion of heart attack patients are admitted under the care of the geriatrician who may not even have access to the coronary care unit. The management of the heart attack patients, therefore, depends upon their age and on the day of the week on which they are admitted.

The long term care of post-infarction patients lies with general practitioners who are bound to follow the protocols set by the hospitals to which they send their patients. In practice there are rarely any discernible protocols and the discharge medication and proposed long term management can be highly variable. Cardiologists should either take over the care of patients with acute myocardial infarction or set clear guidelines for their management and after care. Good practice demands that patients receive the benefits of the most up to date evidence and that this is applied consistently.

I believe that "the potential to reduce the risk of a further major ischaemic event in patients with established coronary disease" is far greater than indicated by the ASPIRE study. The minor failings of cardiologists identified pale into insignificance compared with the failures of a system which ensures that most coronary patients are treated by doctors with no particular interest in their illness.

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1 ASPIRE Steering Group. A British Cardiac Society survey of the potential for the secondary prevention of coronary disease: ASPIRE (Action on Secondary Prevention through Intervention to Reduce Events) *Principal results*. *Heart* 1996;75:334–42.
2 Stevenson JC, Godsland IF, Wynn V. Cardiologists rebuked. *Lancet* 1994;344:1557.
3 Wood DA. Cholesterol lowering does have a role in secondary prevention. *Br Heart J* 1995;73:4–5.